

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Worcester</u> Village or City <u>near Snow Hill</u>		9408 <u>189</u>		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>351</u>	
2 FULL NAME <u>Henrietta Allen</u>		No. _____		St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>4 25 1913</u> (Month) (Day) (Year)		7 AGE <u>1 yrs. 4 mos. 10 ds.</u> If LESS than 1 day, _____ hrs. OR _____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Md.</u>					
PARENTS	10 NAME OF FATHER <u>Iuring Allen</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Maggie Sturgis</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Iuring Allen</u> (Address) <u>Newark, Md.</u>					
15 Filed <u>9/4 1914</u> <u>LeRoy Smith</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept. 4 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred on the date stated above, at <u>8 P.</u> m. The CAUSE OF DEATH* was as follows: <u>no doctor in attendance. Had deep cold & cough. mother died recently with consumption.</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary _____					
(Signed) <u>LeRoy Smith L. Reg.</u> , M. D. <u>9/4 1914</u> (Address) <u>Snow Hill</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Cedar Chapel Cem.</u> DATE OF BURIAL <u>9/5 1914</u>					
20 UNDERTAKER <u>Wm S. Williams</u> ADDRESS <u>Snow Hill</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
DEC 4 1914
BUREAU, V. S.
OCT 5 1914
BUREAU, V. S.
sent out to be signed
by local Registrar

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1 PLACE OF DEATH County <u>Maryland</u>		9409		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Berlin</u>		(No. <u>4</u>)		Registration Dist. No. <u>355</u>	
2 FULL NAME <u>Edward Ayers</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Col.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>Sept. not know, 1843</u> (Month) (Day) (Year)					
7 AGE <u>71</u> yrs. — mos. — ds.		If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Md.</u>					
PARENTS	10 NAME OF FATHER <u>Linton Ayers</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Maret Ayers</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary Ayers</u> (Address) <u>1 Berlin Md.</u>					
15 Filed <u>Dec 11</u> 191 <u>4</u> <u>St. L. Kalloway</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept. 24</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept 22</u> , 191 <u>4</u> to <u>Sept. 28</u> , 191 <u>4</u> that I last saw him alive on <u>Sept 28</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>4</u> p. m. The CAUSE OF DEATH* was as follows: <u>Malaria from</u> (Duration) yrs. mos. ds. Contributory <u>Sudden failure of heart</u> Secondary <u>due to weakness</u> (Duration) yrs. mos. ds. (Signed) <u>Edw. Holland</u> , M. D. , 191 <u>4</u> (Address) <u>Berlin Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.....					
19 PLACE OF BURIAL OR REMOVAL <u>German town Cemetery</u>				DATE OF BURIAL <u>Oct 1</u> , 191 <u>4</u>	
20 UNDERTAKER <u>J. H. Burdette & Co</u>				ADDRESS <u>Berlin Md</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

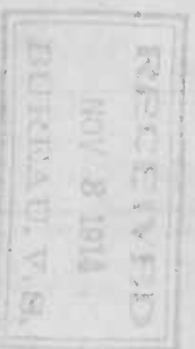
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

9410

County Worcester

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 353

Village or City Bishop

(No. ,

St; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Ethel Bishop

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) DIVORCED

6 DATE OF BIRTH Sept 23, 1877 (Month) (Day) (Year)

7 AGE 37 yrs. 0 mos. 1 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work. House-wife. (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Peter Blades Bishop.

11 BIRTHPLACE OF FATHER (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rachel Davis.

13 BIRTHPLACE OF MOTHER (State or country) Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rachel Davis

(Address) Bishop, Md.

15 Filed Sept 24, 1914 G. W. R. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 24, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1914, to Sept. 24, 1914.

that I last saw her alive on Sept. 23, 1914.

and that death occurred on the date stated above, at 8.15 Am.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 1 yrs. mos. ds.

Contributory Mitral regurgitation. (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) J. R. Bishop, M. D. 9/24/1914 (Address) SHOWELL, MD.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Family Cemetery Sept 25, 1914

20 UNDERTAKER ADDRESS P. F. Watson Sillyville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

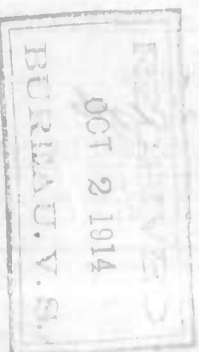
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.*; *Bronchopneumonia* (secondary), *10 d.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Worcester

9411

64

Village or City

Snow Hill

(No.

St.

Ward)

Registration Dist. No.

351

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Deah F. Butler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

Oct.

(Month)

(Day)

1857

(Year)

7 AGE

56 yrs.

11 mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Hiram Phillips

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Deah Taylor

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alonso Butler

(Address)

Girdlestone B.P.O.

15

Filed

9/13, 1914

L. E. Boy Smith

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept

11

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 22nd

1913, to

Sept 11th

1914.

that I last saw him alive on

Sept 8th

1914.

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Brain Degeneration followed by Paralysis

(Duration) yrs. 10 mos. 2 ds.

Contributory
Secondary

Valvular disease of heart

(Duration) yrs. 6 mos. ds.

(Signed)

Sept 12th

(Address)

Paul Jones, M. D.
Snow Hill Rd

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cassowango Church and Sept 13, 1914

20 UNDERTAKER

ADDRESS

W. P. Heam, Snow Hill

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

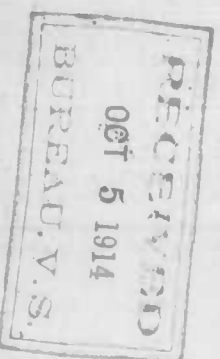
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Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 9412
County Howard

Village or City Pennock City (No. 28) St. Ward

Registration Dist. No. 350

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Minnie E. Clarke

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH July 27, 1866
(Month) (Day) (Year)

7 AGE 48 yrs. 2 mos. 7 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) Household work

9 BIRTHPLACE (State or country) Dorchester Co.

10 NAME OF FATHER Stephen Mills

11 BIRTHPLACE OF FATHER (State or country) Dorchester Co.

12 MAIDEN NAME OF MOTHER Mary Bonahoe

13 BIRTHPLACE OF MOTHER (State or country) Worcester Co.

14 THE ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Annie Mills

(Address) Pennock City, Md.

15 Filed 9/30, 1914 Ephraim Hillman

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1914, to Sept 29, 1914.

that I last saw him or her alive on Sept 29, 1914.

and that death occurred on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Intermittent tuberculosis

(Duration) many years yrs. mos. ds.

Contributory moderate hypertension
Secondary during work

(Duration) yrs. mos. ds.

(Signed) R. Hechler, M. D.
Sept 29, 1914 (Address) Pennock City, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Pennock City, Md. DATE OF BURIAL 9/30, 1914

20 UNDERTAKER Stephens & Son ADDRESS Pennock

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

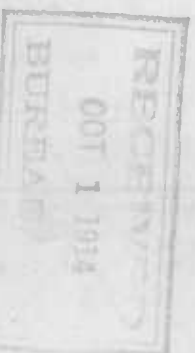
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. - As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Worcester Co. 9413
near Pocomoke
Village or City (No. _____) St.; Ward _____

2 FULL NAME Hester Cluff

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Don't know Sk., 1817
(Month) (Day) (Year)

7 AGE 97 yrs. Sk. mos. Sk. ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Little General Store
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Don't know

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (State or country) Don't know

12 MAIDEN NAME OF MOTHER () Alice

13 BIRTHPLACE OF MOTHER (State or country) Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Coulborne
(Address) Pocomoke City

15 Filed 9/3, 1914 Edmund Williams
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 350

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 18, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1914, to Aug 18, 1914,
that I last saw her alive on Aug 18, 1914,

and that death occurred on the date stated above, at 8:15 p.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
Don't know (Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary
U. E. Particis (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Sept 3rd, 1914 (Address) Pocomoke City, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Trinity Coloma DATE OF BURIAL 9/3, 1914

20 UNDERTAKER Robinson Bn ADDRESS Pocomoke

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

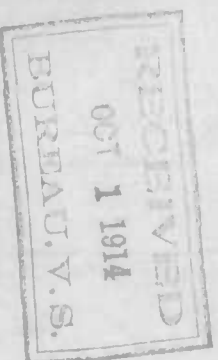
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 9414
County Worcester

Village or City New Pocomoke (No. 1) St. Ward

2 FULL NAME Bessie Collins

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 350

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE yes 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH don't know, 1 (Month) (Day) (Year)

7 AGE 32 yrs. about mos. ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Worcester Co

10 NAME OF FATHER Thomas Schoolfield

11 BIRTHPLACE OF FATHER (State or country) don't know

12 MAIDEN NAME OF MOTHER Carsie Schoolfield

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Noah Collins

(Address) Premake City

15 Filed 9/28, 1914 Ephraim Hillman

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 27, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1914 to Sept 25, 1914

that I last saw him alive on Sept 25, 1914

and that death occurred on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Myocardial infarction
caused by suppurative focus

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) D. C. Brown, M. D.
9/28, 1914 (Address) Premake

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. James DATE OF BURIAL 9/29, 1914

20 UNDERTAKER Stebbins & Son ADDRESS Premake

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

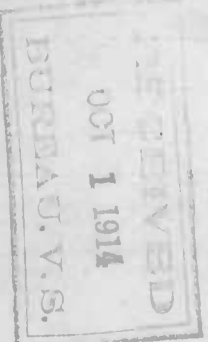
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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9415

1 PLACE OF DEATH

County

Worcester

Village or City

Snow Hill

(No.

79

St.;

Ward)

Registration Dist. No.

351

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Edward Collins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

*Feb**8**1845*

(Month)

(Day)

(Year)

7 AGE

*69**yrs.**6**mos.**29**ds.*

If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

fisherman

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

James Collins

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ann T. Hudson

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Collins

(Address)

Gordons Md.

15

Filed

*9/4**1914**W. T. Hean*

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*9**2**1914*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

*8/15**1914*

to

*9/2**1914*

that I last saw him alive on

*9/2/14**1914*and that death occurred on the date stated above, at *6 p* m.

The CAUSE OF DEATH* was as follows:

Endocarditis (mitral regurgitation)

(Duration)

*several**yrs.**mos.**ds.*Contributory
Secondary

(Duration)

*yrs.**mos.**ds.*

(Signed)

E. W. Hean

M. D.

*9/4**1914*

(Address)

Snow Hill Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

*yrs.**mos.**ds.*

In the

State

*yrs.**mos.**ds.*

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Gordons Md.**Sept. 4**1914*

20 UNDERTAKER

ADDRESS

W. T. Hean Snow Hill

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marras-mus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

9416

1 PLACE OF DEATH

County WorcesterVillage or City Snow Hill

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Erastus S. LashillRegistration Dist. No. 351

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July 27, 1850
(Month) (Day) (Year)

7 AGE 64 yrs. 1 mos. 25 ds. 1 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Dentist
(b) General nature of industry, business, or establishment in which employed (or employer) Dental work

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James A. Lashill

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susanna P. Lashill

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. L. Collins(Address) Snow Hill

15 Filed 9/22, 1914 W. T. Hearn REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 / 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10/1, 1914 to 9/21, 1914

that I last saw him alive on 9/21, 1914

and that death occurred on the date stated above, at 7-30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder
(Diagnosis verified by operation)
(Duration) 1+ yrs. mos. ds.

Contributory
Secondary Cachexia (Duration) yrs. mos. ds.

(Signed) W. T. Hearn, M. D.
9/22, 1914 (Address) Snow Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL P. & C. Snow Hill DATE OF BURIAL Sept. 23, 1914

20 UNDERTAKER W. T. Hearn ADDRESS Snow Hill

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

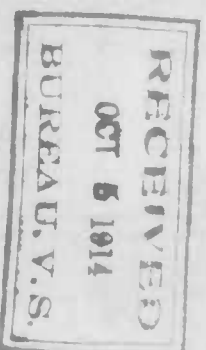
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic catarrhal heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Truemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 9417
 County Princeton
 Village or City Princeton City (No. 64) St. _____ Ward _____
 2 FULL NAME Rettie Ann Davis
 Registration Dist. No. 350

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)
 6 DATE OF BIRTH January 15, 1829
 (Month) (Day) (Year)
 7 AGE 85 yrs. 8 mos. 10 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Retired farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Princeton Co.

10 NAME OF FATHER Isaac J. Davis
 11 BIRTHPLACE OF FATHER (State or country) Princeton Co.
 12 MAIDEN NAME OF MOTHER Susan Webb
 13 BIRTHPLACE OF MOTHER (State or country) Princeton Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Miss Annie Davis
 (Address) Princeton City, Md.

15 Filed 9/26, 1914 Edmund Hillman
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 350

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 25, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 21st, 1914, to Sept 25, 1914,

that I last saw him alive on Sept 25, 1914

and that death occurred on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH was as follows:

Heart (plegia)
Apoplexy
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory Arteriosclerosis
 Secondary Heart
 (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. Leobach, M. D.
Sept 26, 1914 (Address) Princeton City, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Episcopal Princeton DATE OF BURIAL 9/27, 1914

20 UNDERTAKER Stowman Bros ADDRESS Princeton

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

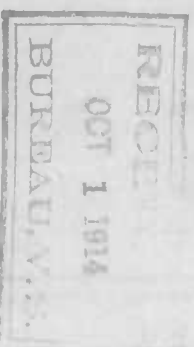
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Worcester

9418

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 351Village or City Snook Hill Md (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Dickerson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Sept-19, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 5 ds. IF LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Worcester Co. Md

10 NAME OF FATHER Mill Dickerson

11 BIRTHPLACE OF FATHER (State or country) Worcester Co. Md

12 MAIDEN NAME OF MOTHER Delia Harmon

13 BIRTHPLACE OF MOTHER (State or country) Worcester Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benjamin Harmon(Address) Snook Hill Md

15 Filed 9/23, 1914 4 LeRoy Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 23, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 1914, to _____, 1914,

that I last saw him alive on _____, 1914,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

No Physician
Convulsions from its birth
until it died

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Paul Jones, M. D.
Sept 23, 1914. (Address) Snook Hill Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL N.Y. Wesley Cemetery DATE OF BURIAL Sept 24, 1914

20 UNDERTAKER H.S. Williams ADDRESS Snook Hill Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scallie," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Norchester

Village or City Snow Hill (No. _____, St.; _____ Ward)

2 FULL NAME Mary Polk Green

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 351

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH October 8, 1844
(Month) (Day) (Year)

7 AGE 69 yrs. 11 mos. 5 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Edward H. Conquest

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary H. Broadwater

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Hudson

(Address) Gladstone Md.

15 Filed 9/15-4 L. Roy Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1914, to Sept. 13, 1914

that I last saw him alive on Sept. 13, 1914

and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Edema of Lungs
Cardiac failure
Chronic Bright's

(Duration) Chronic yrs. ____ mos. ____ ds.

Contributory Chronic Bright's Secondary

(Duration) Chronic for years yrs. ____ mos. ____ ds.

(Signed) Walter T. Richards, M. D.

Sept. 14, 1914 (Address) Snow Hill Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Accomac Co. on farm DATE OF BURIAL Sept. 15, 1914

20 UNDERTAKER W. T. Hearn ADDRESS Snow Hill

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

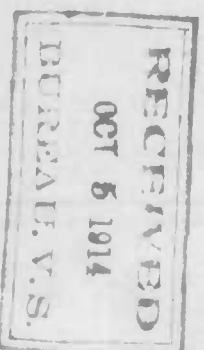
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

9420

County

Harcourt

Village or City

Shorewell

(No.

MIL

St.; Ward)

Registration Dist. No.

355

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Daisy E. Hadden

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Dec. 31

1890

(Month)

(Day)

(Year)

7 AGE

23

yrs.

9

mos.

18

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

William Hadden

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Haddon

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daisy E. Hadden

(Address)

Shorewell MIL

15

Filed

9/23-

1914

W. H. Haddon

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 21

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1

1914

to

Sept 20

1914

that I last saw him alive on

20

1914

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (consumption)

(Duration) 6 yrs. 8 mos. 21 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Robert P. Collins, M. D.

Sept 21

1914

(Address)

Baltimore, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Taylorville Cemetery

Sept 22

1914

20 UNDERTAKER

ADDRESS

J. W. Burbage & Co

Baltimore, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

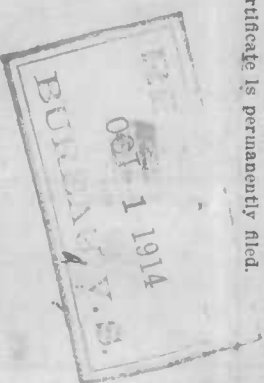
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH

9421

County

Worcester

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

357

Village or City

Snow Hill

(No.

St.;

Ward)

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Leonard Hancock Jr.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) ☒ SINGLE

6 DATE OF BIRTH

April 21, 1914
(Month) (Day) (Year)

7 AGE

0 yrs. *5* mos. *0* ds. OR *1* day, *5* hrs. *0* min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Leonard S. Hancock

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Bessie Shockley

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leonard Hancock

(Address)

Snow Hill, R.F.D.

15

Filed

9/22, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

9/21, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

9/20, 1914 to *9/21, 1914*

that I last saw him alive on *9/21, 1914*

and that death occurred on the date stated above, at *6 a.* m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) *4* yrs. *4* mos. *4* ds.

Contributory
Secondary

(Duration) *4* yrs. *4* mos. *4* ds.

(Signed)

E. E. Evershart

M. D.

9/22, 1914 (Address) *Snow Hill, Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *0* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds.

Where was disease contracted,
It not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. P. Amstutz Snow Hill Sept 22, 1914

20 UNDERTAKER

ADDRESS

W. T. Hearn Snow Hill

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

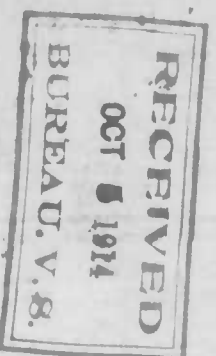
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH 9422County WorcesterVillage or City Snowsice md (No. _____)

St. _____ Ward _____

Registration Dist. No. 351

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Flarence Hayward

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Dec 27

(Month)

(Day)

1899

(Year)

7 AGE

14 yrs. 8 mos. 23 ds.

It LESS than
1 day, _____ hrs.
OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

Same

9 BIRTHPLACE

(State or country)

Snowsice md

PARENTS

10 NAME OF FATHER

Stephen Powell

11 BIRTHPLACE OF FATHER

(State or country)

Worcester Co md

12 MARIEN NAME OF MOTHER

Annie Hayward

13 BIRTHPLACE OF MOTHER

(State or country)

Worcester Co md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Hayward

(Address)

Snowsice md

15

Filed 9/22, 191 44 LeRoy Smith

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 20

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 20, 191 4, to Sept 20, 191 4.that I last saw her alive on Sept 20, 191 4and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Accident, Kicked by horse(Duration) 15 hoursContributory
Secondary

(Signed)

John L. Riley

(Duration)

_____ yrs. _____ mos. _____ ds.

M. D.

Sept 21, 191 4 (Address) Snowsice md

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

_____ yrs. _____ mos. _____ ds.

In the

State

_____ yrs. _____ mos. _____ ds.

Where was disease contracted,
It not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ebenezer CemeterySept 22, 191 4

20 UNDERTAKER

ADDRESS

H. S. WilliamsSnowsice md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

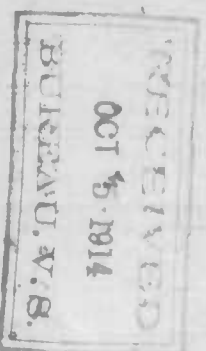
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1 PLACE OF DEATH

9423

County

Harris

Village or City

Pikesville

(No.

St.;

Ward)

Registration Dist. No.

350

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thos. J. Henderson Jr.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word) ✓

6 DATE OF BIRTH

May 4th, 1914
(Month) (Day) (Year)

7 AGE

4¹/₂ yrs. 11 mos. 11 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE

(State or country)

Md.

PARENTS

10 NAME OF FATHER

Thos. J. Henderson

11 BIRTHPLACE OF FATHER (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Sels Carey

13 BIRTHPLACE OF MOTHER (State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos. J. Henderson

(Address)

Pikesville, Md.

15

Filed

9/15

191

E. Frank Hallman

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 350

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 12th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 28th, 1914, to Sept 14th, 1914,

that I last saw him alive on Sept 13th, 1914,

and that death occurred on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion
(Duration) yrs. 15 mos. 15 ds.

Contributory
Secondary

(Duration) yrs. 1 mos. 15 ds.

(Signed)

J. M. Wilson, M. D.

Sept 15th, 1914 (Address) Pikesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Methodist P. Church 9/15, 1914

20 UNDERTAKER

ADDRESS

Henderson Bros Pikesville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

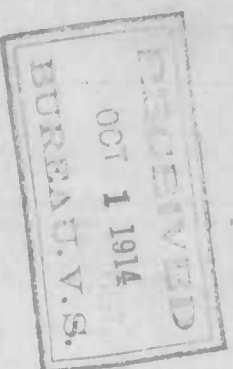
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not painfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Mairasms," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

9424

County WorcesterSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 355Village or City Berlin md (No. 104) St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Lebara E. Henry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) —

6 DATE OF BIRTH May 21, 1914
(Month) (Day) (Year)

7 AGE — yrs. 4 mos. 1 ds. IF LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work —(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Thurley Henry

11 BIRTHPLACE OF FATHER (State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Norma Berry

13 BIRTHPLACE OF MOTHER (State or country)

Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norma Henry(Address) Berlin md

15

Filed 9/24, 1914 W. H. Hecceway

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 23, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1914, to Sept 23, 1914.that I last saw him alive on Sept 23, 1914.and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cholera dysenteriae(Duration) 5 yrs. 3 mos. 3 ds.Contributory
Secondary(Duration) — yrs. — mos. — ds.(Signed) W. H. Hecceway, M. D.9/24, 1914 (Address) Berlin md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.Where was disease contracted, If not at place of death? —Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL

Berlin md

DATE OF BURIAL

Sept 24, 1914

20 UNDERTAKER

Lauris J. Evans Berlin md

ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

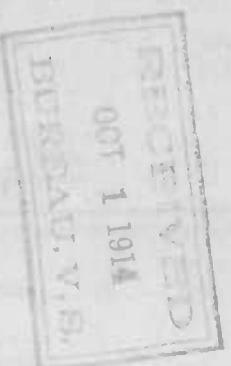
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH 9425
County Worcester

Village or City Stockton (No. 92)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 354

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Abbie L. Hudson

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Female ⁴ COLOR OR RACE white ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

⁶ DATE OF BIRTH July 31, 1852
(Month) (Day) (Year)

⁷ AGE 62 yrs. 1 mos. 20 ds. OR 1 day, 20 hrs. OR 1 min. ?
If LESS than 1 day, hrs.

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) None

⁹ BIRTHPLACE (State or country) Worcester Co., Md.

PARENTS
¹⁰ NAME OF FATHER Unknown
¹¹ BIRTHPLACE OF FATHER (State or country) Unknown
¹² MAIDEN NAME OF MOTHER Mary Hudson
¹³ BIRTHPLACE OF MOTHER (State or country) Worcester Co., Md.

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. C. Hudson
(Address) Stockton, Md.

¹⁵ Filed 9/22, 1914 W. C. Payne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH September 20, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1914 to Sept. 19, 1914, that I last saw her alive on Sept. 19, 1914

and that death occurred on the date stated above, at 1230 P. M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) 8 yrs. 8 mos. 8 ds.

Contributory
Secondary
(Duration) 8 yrs. 8 mos. 8 ds.
(Signed) John D. Dickerson, M. D.
Sept. 21, 1914. (Address) Stockton, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 8 yrs. 8 mos. 8 ds. In the State 8 yrs. 8 mos. 8 ds.
Where was disease contracted, If not at place of death?
Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL Stockton M E Cemetery ²⁰ DATE OF BURIAL 9/22, 1914
²⁰ UNDERTAKER Hemlock & Smack ADDRESS Stockton, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Worcester 9426Village or City Bishop R. & D. (No. 1)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 553

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Wardson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Sept 24, 1914
(Month) (Day) (Year)

7 AGE 1 hr. If LESS than day, hrs.
Yrs. mos. ds. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Parker Wardson
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Henrie Wardson
13 BIRTHPLACE OF MOTHER (State or country) Bishop Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Wardson(Address) Bishop R. & D. No. 1

15 Filed Sept 24, 1914 by Garnett Rayne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 24, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1914, to Sept 24, 1914.

that I last saw him alive on Sept 24, 1914.

and that death occurred on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

The mother was only pregnant 7 months by 1 day only lived 1 hour with
(Duration) yrs. mos. ds.

Contributory Secondary

(Signed) Rollin P. Collins, M. D.
Sept 24, 1914. (Address) Bishopville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lyndal Cemetery Sept 25, 1914

20 UNDERTAKER ADDRESS

W. J. Hudson Bishop Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

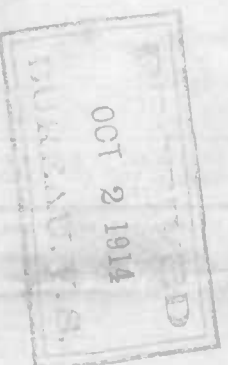
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæ-mia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS—state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Monrovia

Village or City Cedar Hall

(No. 92)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 380

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary C. Sumbler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Nov 10, 1856
(Month) (Day) (Year)

7 AGE 64 yrs. 10 mos. 10 ds. OR 1 day, 1 hrs. 1 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Md.

PARENTS
10 NAME OF FATHER Donat Sumbler
11 BIRTHPLACE OF FATHER (State or country) Donat Sumbler
12 MAIDEN NAME OF MOTHER Donat Sumbler
13 BIRTHPLACE OF MOTHER (State or country) Donat Sumbler

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. J. Sumbler
(Address) Frederick City

15 Filed 7/16, 1914 G. J. Sumbler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1914 to Sept 14, 1914
that I last saw him alive on Sept. 14, 1914
and that death occurred on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Colapso
(Duration) four hrs. 10 mos. 5 ds.
Contributory Heart
Secondary Tricuspid
(Duration) 5 yrs. 5 mos. 5 ds.
(Signed) J. M. Wilson, M. D.
Sept. 15, 1914 (Address) Frederick City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 4 yrs. 10 mos. 10 ds. In the State 4 yrs. 10 mos. 10 ds.
Where was disease contracted, If not at place of death?
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Methodist Church DATE OF BURIAL 9/16, 1914

20 UNDERTAKER Shirman Bros ADDRESS Frederick

Altman & Bud

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

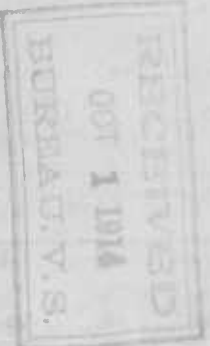
[Approved by U. S. Census and American Public Health
Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not rainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial nephritis*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Seuile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 9428
County Worcester

Village or City Sallyville Del. (No. R.F.D. No. 1)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 353

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Remeth J. Magel or Hudson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 8, 1913
(Month) (Day) (Year)

7 AGE 1 yrs. 2 mos. 18 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Delaware

PARENTS 10 NAME OF FATHER Archa Hudson 11 BIRTHPLACE OF FATHER (State or country) Delaware 12 MAIDEN NAME OF MOTHER Lydian J. Magel 13 BIRTHPLACE OF MOTHER (State or country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Lydian J. Magel (Address) Sallyville Del. R.F.D. No. 1

15 Filed Sept 27, 1914 Timothy Boyne REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 27, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1914, to Sept 20, 1914, that I last saw him alive on Sept 20, 1914

and that death occurred on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows: Heart disease

(Duration) yrs. mos. ds.

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) Sept 27, 1914 (Address) R.F.D. No. 1, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Long cemetery DATE OF BURIAL Sept 27, 1914

20 UNDERTAKER P. F. Watson ADDRESS Sallyville Del.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 2 1914

U. S. A. T. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 9429		STATE OF MARYLAND	
County <u>Harvest</u>		CERTIFICATE OF DEATH	
Village or City <u>Freemake</u> (No. <u>104</u>)		Registration Dist. No. <u>350</u>	
2 FULL NAME <u>Kesley S. Miller</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <input checked="" type="checkbox"/>	
6 DATE OF BIRTH <u>Mar 7</u> , 19 <u>14</u> (Month) (Day) (Year)			
7 AGE <u>4</u> yrs. <u>25</u> mos. <u>25</u> ds.		If LESS than 1 day, <u> </u> hrs. <u> </u> min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u> </u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u>			
9 BIRTHPLACE (State or country) <u>Md.</u>			
PARENTS	10 NAME OF FATHER <u>C. H. Miller</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>		
	12 MAIDEN NAME OF MOTHER <u>Louis Carey</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>C. H. Miller</u> (Address) <u>Freemake City</u>			
15 Filed <u>9/2</u> , 19 <u>14</u> <u>James H. Miller</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Sept. 1</u> , 19 <u>14</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept. 1</u> , 19 <u>14</u> to <u>Sept. 1</u> , 19 <u>14</u> , that I last saw him alive on <u>Sept. 1</u> , 19 <u>14</u> , and that death occurred on the date stated above, at <u>3:30 p.m.</u> The CAUSE OF DEATH* was as follows: <u>Splenic rupture free heart</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. Contributory <u> </u> Secondary <u> </u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. (Signed) <u>J. H. Miller</u> , M. D. <u>Sept. 2</u> , 19 <u>14</u> (Address) <u>Freemake City</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, It not at place of death? <u> </u> Former or usual residence <u> </u>			
19 PLACE OF BURIAL OR REMOVAL <u>McDonald</u>		DATE OF BURIAL <u>9/2</u> , 19 <u>14</u>	
20 UNDERTAKER <u>Shannon Bros</u>		ADDRESS <u>Freemake</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

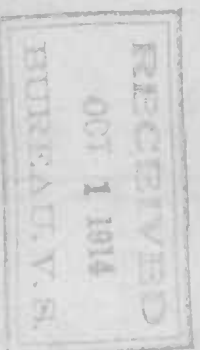
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Worcester</u>		9430	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Snowhill md</u> (No. _____)		Registration Dist. No. <u>357</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Francis Purnell</u>		St.; Ward _____		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>May 3-</u> , 191 <u>4</u> (Month) (Day) (Year)				
7 AGE ____ yrs. <u>4</u> mos. <u>1</u> ds. OR ____ min. ?		If LESS than 1 day, ____ hrs.		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>				
9 BIRTHPLACE (State or country) <u>Snowhill md</u>				
PARENTS	10 NAME OF FATHER <u>Martendal Purnell</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Worcester Co md</u>			
	12 MAIDEN NAME OF MOTHER <u>Myrtle Selby</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Greenback Va</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Martendal Purnell</u> (Address) <u>Snowhill md</u>				
15 Filed <u>9/7</u> , 191 <u>4</u> <u>LeRoy Smith</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Sept 6th</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred on the date stated above, at <u>10 o'clock a.m.</u> The CAUSE OF DEATH* was as follows: <u>No Physician</u> <u>Infantile Diarrhoea</u> (Duration) ____ yrs. ____ mos. <u>14</u> ds.				
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.				
(Signed) <u>Paul Jones</u> , M. D. <u>Sept 6th</u> , 191____ (Address) <u>Snowhill md</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Baptist Cemetery</u>				DATE OF BURIAL <u>Sept 7</u> , 191 <u>4</u>
20 UNDERTAKER <u>H. S. Williams</u>				ADDRESS <u>Snowhill</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

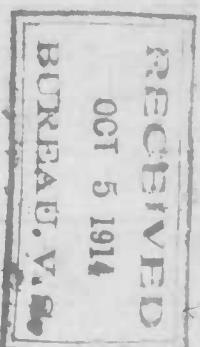
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium," "Genital," "Sensile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SCIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **9431**
County Worcester

Village or City Snow Hill (No. _____)

2 FULL NAME Ashur J. Richardson

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 357

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Sept 21, 1855
(Month) (Day) (Year)

7 AGE 58 yrs. 11 mos. 23 ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work capitalist
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Littleton J. Richardson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet E. Scarborough

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Virginia L. Nash

(Address) Philadelphia

15 Filed 9/15, 1914 4 LeRoy Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1914 to Sept 14, 1914

that I last saw him alive on Sept 14, 1914

and that death occurred on the date stated above, at 630 P m.

The CAUSE OF DEATH* was as follows:

Diabetic Mellitus

(Duration) 3 yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John L. Riley, M. D.
Sept 14, 1914 (Address) Snow Hill, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, It not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Ashington, Texas DATE OF BURIAL (2), 1914

20 UNDERTAKER W. T. Evans Snow Hill ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 9432
County Worcester

Village or City Snow Hill (No. 164) St. Ward

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 351

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Harnett E. Richardson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Sept. 23, 1826
(Month) (Day) (Year)

7 AGE 87 yrs. 14 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Richard Scarborough

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harnett E. White

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Leshner Smith
(Address) Laredo, Texas

15 Filed 9/19, 1914 W. T. Hearn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 17, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1914, to Sept 17, 1914, that I last saw her alive on Sept 17, 1914

and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 1 yrs. 4 mos. 4 ds.

Contributory
Secondary

(Signed) John L. Riley, M. D.
Sept 17, 1914 (Address) Snow Hill Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. - In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL M. E. Cemetery Snow Hill DATE OF BURIAL Sept. 19, 1914

20 UNDERTAKER W. T. Hearn ADDRESS Snow Hill

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

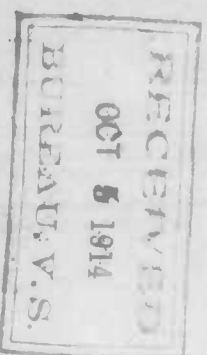
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS or INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Worcester

9433

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 355Village or City Berlin md (No. 79)

St.: _____ Ward: _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Rider

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

colored5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
widowed

6 DATE OF BIRTH

no record about 1842
(Month) (Day) (Year)

7 AGE

52

yrs. _____ mos. _____ ds. OR _____ min. ?

If LESS than 1 day, _____ hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

George Rider

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Larah Pitts

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maryling Purnell

(Address)

Berlin md

15

Filed

9/20

1914

W. L. Halloway

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 16, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 1914 to Sept 16 1914that I last saw him alive on Sept 16 1914and that death occurred on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
(Duration) _____ yrs. _____ mos. _____ ds.Contributory
SecondaryDropsy

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. J. Holland, M. D.Sept 17, 1914 (Address) Berlin md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Berlin md

DATE OF BURIAL

Sept 19, 1914

20 UNDERTAKER

Leah J. Evans

ADDRESS

Berlin md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH County <u>Harvester</u>		9434		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Whaleyville R.F.D. No. 1</u>		(No. <u>11</u>)		Registration Dist. No. <u>853</u>	
2 FULL NAME <u>Frank Scott</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>July 6, 1914</u> (Month) (Day) (Year)					
7 AGE <u>1</u> yrs. <u>27</u> mos. <u>27</u> ds. <u>1</u> LESS than 1 day, <u>27</u> hrs. OR <u>27</u> min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Stanley Scott</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Lisa West</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Delaware</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Stanley Scott</u> (Address) <u>Whaleyville R.F.D. No. 1</u>					
15 Filed <u>Sept 3, 1914</u> <u>Trinity Bayne</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept 3, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That <u>deceased</u> deceased from <u>Sept 2, 1914</u> to <u>Sept 3, 1914</u> that I last saw him alive on <u>Sept 3, 1914</u> and that death occurred on the date stated above, at <u>3:00</u> p. m. The CAUSE OF DEATH* was as follows: <u>Spur wound</u> <u>There was no doctor</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds.					
Contributory Secondary (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds.					
(Signed) <u>Trinity Bayne</u> , M. D. (Address) <u>Bishop Rd</u> , 191					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u> </u>					
19 PLACE OF BURIAL OR REMOVAL <u>Evergreen</u>				DATE OF BURIAL <u>Sept 3, 1914</u>	
20 UNDERTAKER <u>P F Nations</u>				ADDRESS <u>Del</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

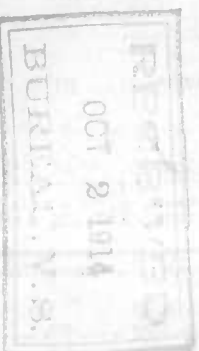
[Approved by U. S. Census and American Public Health Association.]

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¹ PLACE OF DEATH 9435
County Warrenton
Village or City Berlin (No. 152) St. _____ Ward _____

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 355

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME No name Infant Showell

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Male ⁴ COLOR OR RACE Cal ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____

⁶ DATE OF BIRTH Sept 3 1914, 1 _____
(Month) (Day) (Year)

⁷ AGE _____ yrs. _____ mos. 2 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

⁹ BIRTHPLACE (State or country) Near Berlin

PARENTS
¹⁰ NAME OF FATHER Daniel Showell
¹¹ BIRTHPLACE OF FATHER (State or country) Maryland
¹² MAIDEN NAME OF MOTHER Lizzie Purnell
¹³ BIRTHPLACE OF MOTHER (State or country) Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE(Informant) Daniel Showell(Address) Berlin Md

¹⁵ Filed Sept 6, 1914 W. H. Haccomby
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Sept 5, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from 9-3, 1914, to 9-5, 1914,
that I last saw him alive on 9-4, 1914.

and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Haemophilia
slight trauma
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Signed) Chas R. Low, M. D.
9-5, 1914 (Address) Berlin Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

¹⁹ PLACE OF BURIAL OR REMOVAL St Pauls Cemetery DATE OF BURIAL Sept 6, 1914

²⁰ UNDERTAKER J. W. Busby & Co ADDRESS Berlin Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—decident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See Instructions on back of certificate.

1 PLACE OF DEATH

9436

County WorcesterSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 357Village or City Near Snow Hill Md (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jarome Victor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH June 15th, 1912
(Month) (Day) (Year)

7 AGE 2 yrs. 3 mos. 5 ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Worcester Co md

PARENTS
10 NAME OF FATHER Jacob E. Victor
11 BIRTHPLACE OF FATHER (State or country) Worcester Co md
12 MAIDEN NAME OF MOTHER Mary Sturgis
13 BIRTHPLACE OF MOTHER (State or country) Worcester Co md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob E Victor
(Address) Snow Hill Md

15 Filed 9/6, 1914 L E Roy Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 4th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1914, to Sept 4, 1914,
that I last saw him alive on Sept 3, 1914

and that death occurred on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis(Duration) _____ yrs. _____ mos. 7 ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. E. Wisehart, M. D.
Sept. 4, 1914 (Address) Snow Hill Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Huth Chable Cemetery DATE OF BURIAL Sept-4, 1914

20 UNDERTAKER E. S. Williams ADDRESS Snow Hill Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

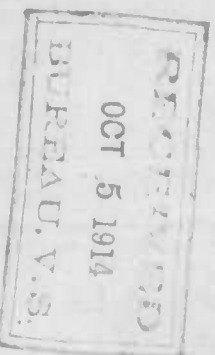
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *10 ds.* Never report *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 9437

County WorcesterVillage or City Snow Hill Md (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 307

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Margie Ward

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May 8th1892

(Month) (Day) (Year)

7 AGE

22 yrs. 4 mos. ds.

If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Service Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

Same

9 BIRTHPLACE

(State or country)

Worcester Co Md

PARENTS

10 NAME OF FATHER

Albert Ward

11 BIRTHPLACE OF FATHER (State or country)

Worcester Co Md

12 MAIDEN NAME OF MOTHER

Annie Ward

13 BIRTHPLACE OF MOTHER (State or country)

Worcester Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Purnell

(Address)

Snow Hill Md

15

Filed

9/10, 1914

REGISTRAR

16 DATE OF DEATH

9 81914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from 8/16, 1914, to 8/23, 1916,that I last saw him alive on 8/23, 1916and that death occurred on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

T. B. of Lungs.(Duration) _____ yrs. 11 mos. _____ ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Marvill D. Luigo, M. D.9/10, 1914 (Address) Marvill D. Luigo

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Wesley Cemetery Sept 12, 1914

20 UNDERTAKER

ADDRESS

H. S. Williams Snow Hill Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

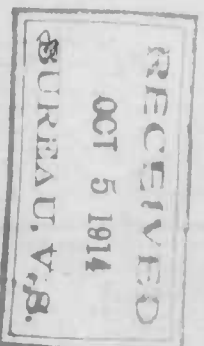
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 9438

County HarvestVillage or City Frederick (No. _____)

St. _____ Ward _____

Registration Dist. No. 350

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 28, 1914
(Month) (Day) (Year)

7 AGE ✓ yrs. ✓ mos. ✓ ds. OR LESS than 1 day. ✓ hrs. ✓ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work ✓(b) General nature of industry, business, or establishment in which employed (or employer) ✓9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Harry J. White11 BIRTHPLACE OF FATHER (State or country) Md.12 MAIDEN NAME OF MOTHER Bess H. Taylor13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry J. White(Address) Frederick City

15 Filed 9/29, 1914 John H. Hillman
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ✓ 1914 to ✓ 1914

that I last saw h. ✓ alive on ✓ 1914

and that death occurred on the date stated above, at ✓ m.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) ✓ yrs. ✓ mos. ✓ ds.

Contributory
Secondary

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) J. H. Wilson, M. D.

Sept 28, 1914 (Address) Frederick City

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ✓ yrs. ✓ mos. ✓ ds. In the State ✓ yrs. ✓ mos. ✓ ds.

Where was disease contracted, If not at place of death? ✓

Former or usual residence ✓

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Episcopal Cemetery 7/29, 1914

20 UNDERTAKER ADDRESS

Shoemaker Bm Pocomoke

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

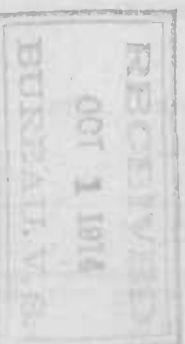
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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sent
out to be
signed
by
local
registar

RECEIVED
DEC 1 1914
BUREAU, V. S.

RECEIVED
OCT 1 1914
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

9440

County

Worcester

Village or City

Near Snowden Md

(No.)

Registration Dist. No.

351

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Geo. R. Young

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

March 29

1893

(Month) (Day) (Year)

7 AGE

20 yrs. 4 mos. 28 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

Same

9 BIRTHPLACE (State or country)

Accomack Va

PARENTS

10 NAME OF FATHER

Frank. Young

11 BIRTHPLACE OF FATHER (State or country)

Accomack Va

12 MAIDEN NAME OF MOTHER

Lyda Savage

13 BIRTHPLACE OF MOTHER (State or country)

Accomack Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank. Young

(Address)

Snowden Md

15

Filed

9/28

191

V. L. Boy Smith

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

9-28

191

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

8/28

1914

to

8/28

1914

that I last saw him alive on

8/27, 1914

and that death occurred on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. 1 mos. 14 ds.

Contributory Secondary

(Duration) yrs. 1 mos. 14 ds.

(Signed)

Marvella R. Rupp

M. D.

9/28

1914

(Address) Snowden Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Whitell Cemetery

Sept. 30, 1914

20 UNDERTAKER

ADDRESS

J. S. Williams

Snowden Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality, as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

